Public Education Employees' Health Insurance Program **Screening Form** / **HEALTHCARE PROVIDER** 



## GET SCREENED FOR YOUR TEAM!

**ADPH Wellness Program** 201 Monroe Street, Suite 986 Montgomery, AL 36104 Phone: 1-800-252-1818

Fax: 1-334-206-0385

| SECTION 1:<br>(To Be Completed by Active or Retired Employee or Spouse)  |   | PRINT CLEARLY WITH<br>A BLACK INK PEN. |   |  |
|--|---|--|---|--|
| Contract Number:   | SSN: (of  | person being screened)                 | ■ Male ■ Contract Holder  |  |
|  |   |  | □ Female □ Spouse   |  |
| Screen Date:   | Birth Date:                                       | D.                                     | aytime Phone Number:  |  |
| Last Name:   | First Name:                                       |  |   |  |
|  |   |  |   |  |
| Screening not performed due to:   Pregnancy Disability   |   |  |   |  |
| What best describes your race/ethni White Hispanic / Latino Black / African American Native Hawaiian / Pacific Islander  | city? Asian Other Native American / Alaska Native | ☐ High Cholesterol                     | you been told you had) any of the following?  High Blood Pressure Diabetes  ication for any of the following?  High Blood Pressure Diabetes |  |
| SECTION 2: (To Be Completed by Provi   | der)  |  |   |  |
| Blood Pressure:  |   | Blood Gluco                            | se: mg/dl   |  |
| Total Cholesterol:   | mg/dl   | Heig                                   | ht: ft in   |  |
| HDL Cholesterol:   | mg/dl   | Weig                                   | ht: Ibs   |  |
| LDL Cholesterol:   | mg/dl   | Wai                                    | st: in  |  |
| Triglycerides  | mg/dl   | Waist-To-Height Ra                     | tio BMI:  |  |
| Has the person being screened used a tobacco product in the last 12 months?  |   |  |   |  |
| <b>CLAIMS FILING INSTRUCTIONS FOR COPAYMENT WAIVER:</b> Under the Affordable Care Act, no copayment is required for one annual preventive routine office visit obtained through an in-network provider (not applicable if a diagnosis associated with the visit). File the claim for the member's office visit with BC/BS for PEEHIP Group #14000. Use the appropriate CPT code for the office visit in order to be reimbursed at 100% of the allowable fee. The patient will be responsible for any other applicable copays, such as lab tests. The copay waiver is not allowed at Urgent Care Centers or Emergency Rooms. Please follow the normal billing procedures for subsequent visits. |   |  |   |  |
|  |   |  |   |  |
| Healthcare Provider N  | ame (Please Print)                                | H                                      | ealthcare Provider Signature  |  |
|  |   |  |   |  |
| Healthcare Provider Type (Please Print)  Healthcare Provider Address & Phone Number (Please Print)   |   |  |   |  |



